MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Princeton Pain Management 3710 Rawlins Dallas TX 75219	MDR Tracking No.: M4-03-7550-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address BOX #: 1 TX Builders Ins. Co. c/o John Fowler PO Box 164040 Austin TX 78716	Date of Injury: Employer's Name: Top Notch Temporaries, Inc. Insurance Carrier's No.: 5730C

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
10/9/02	**10/14/02**	**97799-CP**	**$2,472.00**	**$2,472.00**

PART III: REQUESTOR'S POSITION SUMMARY

4/9/03: "Please find enclosed documentation regarding unpaid bills for services…the carrier initially reduced our bills due to "C-negotiated contract." This is a mistake…We do not have any contracts with TX Builders Ins. Co…All DOS have been submitted for reconsideration…The carrier, however, has chosen to continue denying these services, despite clear evidence that their denials are inaccurate. I have included copies of all medical documentation…EOB's…"

PART IV: RESPONDENT'S POSITION SUMMARY

7/2/03: "…This dispute is predicated upon TX Builders Insurance Company's appropriate decision to reimburse a Chronic Pain Management Program at a fair and reasonable rate of reimbursement….Corvel inadvertently utilized a 'C' exception code when they reduced the…charges to a "Fair & Reasonable" reimbursement. Corvel…is reissuing a corrected EOB with the appropriate 'M' exception code…The requestor bears the burden of proof that the fees reimbursed by an insurance carrier are not fair and reasonable…The rate of reimbursement remitted by TX Builders Insurance Co. is consistent with the rate paid to other providers of the billed services…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

CPT Code 97799-CP for DOS 10/9/02, 10/11/02 and 10/14/02 were initially denied with "C – Negotiated Contract Price." Reconsideration EOB indicating 'same reason as first denied' therefore back to the negotiated contract price. Requestor does not have a contract with the respondent.

Requestor submitted convincing evidence to support usual and customary charges according to 133.1 (a)(8) and MFG/GI VI. Additional reimbursement recommended in the amount of $2,472.00.

PART VI: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $2,472.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

	Carol Lawrence	03/29/05
Authorized Signature	Typed Name	Date of Order

PART VII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____